

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

AL EVERITT BOYETT, JR.,)	
)	
Plaintiff,)	
)	
v.)	CIVIL ACTION NO. 2:05-CV-966-D
)	
ANTHONY CLARK, SHERIFF, <i>et al.</i> ,)	
)	
Defendants.)	

AFFIDAVIT OF ANNETTE CAIN, L.P.N.

Before me, the undersigned notary public, in and for said County and State, personally appeared **Annette Cain, L.P.N.**, who, after first being duly sworn by me, deposes and states as follows:

1. My name is Annette Cain, L.P.N. I am over the age of 19 years and have personal knowledge of the facts contained herein.
2. I am currently employed by Southern Health Partners, Inc. ("SHP") as the medical team administrator for the Covington County Jail. Attached as Exhibit A is a true and correct copy of inmate Al Everitt Boyett's entire medical chart. These records were made at the time of the events referenced therein and were made and kept in the regular course of SHP's business.


Annette Cain, L.P.N.

STATE OF ALABAMA)
COUNTY OF Madison)

I, the undersigned Notary Public in and for said county in said state, hereby certify that Annette Cain, whose name is signed to the foregoing and who is known to me, acknowledged before me that, being fully informed of the contents of said instrument, she executed the same voluntarily on the day the same bears date.

GIVEN UNDER MY HAND and official seal on this the 2 day of March, 2006.



Notary Public
My Commission Expires: 12-3-2007

EXHIBIT A

Covington County Sheriff	MEDICAL SCREENING FORM AL EVERITT BOYETT (S416081511)	Booking Number 200007743 Booking Date MAY 3rd, 2005
Printed: Tue May 03, 2005		
ADMISSION OBSERVATIONS		
Is inmate conscious? <input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate capable of responding? <input checked="" type="radio"/> Y <input type="radio"/> N	Can inmate walk on own? <input checked="" type="radio"/> Y <input type="radio"/> N
Any difficulty breathing? <input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate hostile/aggressive? <input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of trauma, bleeding, wounds or illness? <input type="radio"/> Y <input checked="" type="radio"/> N
Did arrest result in injury? <input type="radio"/> Y <input checked="" type="radio"/> N	Any fever, swollen lymph nodes, or jaundice? <input type="radio"/> Y <input checked="" type="radio"/> N	Is skin in good condition and free of vermin? <input type="radio"/> Y <input checked="" type="radio"/> N
Is inmate under obvious influence of alcohol? <input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate under obvious influence of drugs? <input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of alcohol or drug withdrawal symptoms? <input type="radio"/> Y <input checked="" type="radio"/> N
Does inmate suggest risk of suicide? <input type="radio"/> Y <input checked="" type="radio"/> N	Do you consider inmate an escape risk? <input type="radio"/> Y <input checked="" type="radio"/> N	
Observations WOULD NOT ANSWER QUESTION ON INFLUENCE OF DRUGS		
INMATE QUESTIONNAIRE		
HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?		
Hepatitis <input checked="" type="radio"/> Y <input type="radio"/> N	Heart Disease <input type="radio"/> Y <input checked="" type="radio"/> N	Mental/Emotional Upset <input checked="" type="radio"/> Y <input type="radio"/> N
Tuberculosis <input type="radio"/> Y <input checked="" type="radio"/> N	Hypertension <input type="radio"/> Y <input checked="" type="radio"/> N	Attempted Suicide <input type="radio"/> Y <input checked="" type="radio"/> N
Sexually Transmitted Disease <input type="radio"/> Y <input checked="" type="radio"/> N	Epilepsy/Convulsions <input type="radio"/> Y <input checked="" type="radio"/> N	Asthma/Emphysema <input type="radio"/> Y <input checked="" type="radio"/> N
Ulcers <input type="radio"/> Y <input checked="" type="radio"/> N	Hemophiliac (bleeder) <input checked="" type="radio"/> Y <input type="radio"/> N	Cancer <input type="radio"/> Y <input checked="" type="radio"/> N
Kidney Trouble <input type="radio"/> Y <input checked="" type="radio"/> N	Aids/Exposed to Aids <input type="radio"/> Y <input checked="" type="radio"/> N	Diabetes <input type="radio"/> Y <input checked="" type="radio"/> N
DT's <input type="radio"/> Y <input checked="" type="radio"/> N	Skin Problems <input type="radio"/> Y <input checked="" type="radio"/> N	Use Insulin <input type="radio"/> Y <input checked="" type="radio"/> N
Drug Addiction <input type="radio"/> Y <input checked="" type="radio"/> N	Alcoholism <input type="radio"/> Y <input checked="" type="radio"/> N	Mental Illness <input type="radio"/> Y <input checked="" type="radio"/> N
Recent Head Injury <input type="radio"/> Y <input checked="" type="radio"/> N	Coughed/Passed Blood <input type="radio"/> Y <input checked="" type="radio"/> N	Recent Hospital Patient <input type="radio"/> Y <input checked="" type="radio"/> N
Recent Treatment <input type="radio"/> Y <input checked="" type="radio"/> N	Use Needles <input checked="" type="radio"/> Y <input type="radio"/> N	False Limbs/Teeth <input type="radio"/> Y <input checked="" type="radio"/> N
Contagious Disease <input type="radio"/> Y <input checked="" type="radio"/> N	Pregnant/Recent Delivery <input type="radio"/> Y <input checked="" type="radio"/> N	
Doctors Name and Address NO		
Health Insurance NO		
Special Diet NO		
Prescriptions/Medications NO		
Drug Allergies NO		
Descriptions		
I have read the above carefully and have answered all questions correctly to the best of my knowledge.		
Inmate's Signature <u>X Refused</u>		Date: _____ Time: _____
Officers's Signature <u>CJ006 Bill Blue</u> CJ006 BLUE, BILL		Date: <u>5-3-05</u> Time: <u>2215</u>

MEDICAL STAFF REVIEWING SCREENING FORM

Southern Health Partners

LAST NAME: Byett FIRST NAME: Al MIDDLE: Everitt INTAKE DATE: 5/3/05 SCREENING DATE: 5/4/05 TIME:
 PREVIOUS INCARCERATIONS: SEX: SOCIAL SECURITY NO.: 416-08-1511 DOB: 1-15-1
 CURRENT INSURANCE COVERAGES? CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION:

VISUAL / MEDICAL OBSERVATION: (Explain all "Yes" Answers) Circle Y or N:

Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral?	YES Y
If yes:	
Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries; needle marks, body vermin?	Y
If yes:	
Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior?	Y
If yes:	
Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol?	Y
If yes:	
Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc.	Y
If yes:	

ASK THE INMATE THESE QUESTIONS: (Explain all "Yes" answers)

Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions?	Y
Other:	
Have you taken or are you taking any medication(s) prescribed for you by a physician?	Y
If yes:	
Are you allergic to any medications, foods, plants, etc.?	Y
If yes:	
Have you fainted or had a head injury within the last 72 hours?	Y
If yes:	
Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease?	Y
If yes: <u>yes - needles + sexual contact last wk.</u>	
Have you been hospitalized by a physician or psychiatrist within the last year?	Y
If yes:	
Have you ever considered or attempted suicide?	Y
If yes:	
Do you have a painful dental condition?	Y
If yes: <u>dental caries</u>	
Are you on a specific diet prescribed by a physician?	Y
If yes:	
Do you use drugs? How often?	Y
What kind? <u>all ETOH use</u>	Last time? <u></u>
Do you use alcohol? How often?	Y
What kind? <u>beer, pot</u>	How much? <u>occasional</u>
Do you use alcohol? How often?	Y
What kind? <u>beer, pot</u>	Last time? <u></u>
How much? <u>4 deep a x</u>	
Females: LMP Date:	Y
Are you pregnant, recently delivered or aborted; on birth control pills; having abdominal pain or discharge?	N/A
If yes:	

NOTE VITAL SIGNS:

Respiration: 18 Pulse: 98 Temperature: 97.7 Blood Pressure: 133/78

HAVE ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE? yes

ARE ALL STATED CHRONIC CONDITIONS NOTED? yes

PPD IMPLANTED? Y OR N ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAYS? yes

REMARKS:

I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication up hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc.

Inmate's Signature: X Al Byett Date: 5/4
 Interviewer's Signature and Title: [Signature] Date: 5/4

Covington County Sheriff

Printed: Wed Jun 08, 2005

MEDICAL SCREENING FORM

AL EVERITT BOYETT (S416081511)

Booking Number

200008027

Booking Date

JUNE 7th, 2005

ADMISSION OBSERVATIONS

Is inmate conscious?	<input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate capable of responding?	<input checked="" type="radio"/> Y <input type="radio"/> N	Can inmate walk on own?	<input checked="" type="radio"/> Y <input type="radio"/> N
Any difficulty breathing?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate hostile/aggressive?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of trauma, bleeding, wounds or illness?	<input type="radio"/> Y <input checked="" type="radio"/> N
Did arrest result in injury?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any fever, swollen lymph nodes, or jaundice?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is skin in good condition and free of vermin?	<input type="radio"/> Y <input checked="" type="radio"/> N
Is inmate under obvious influence of alcohol?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate under obvious influence of drugs?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of alcohol or drug withdrawal symptoms?	<input type="radio"/> Y <input checked="" type="radio"/> N
Does inmate suggest risk of suicide?	<input type="radio"/> Y <input checked="" type="radio"/> N	Do you consider inmate an escape risk?	<input type="radio"/> Y <input checked="" type="radio"/> N		

Observations

INMATE APPEARS FINE AT TIME OF INTAKE

INMATE QUESTIONNAIRE

HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?

Hepatitis	<input checked="" type="radio"/> Y <input type="radio"/> N	Heart Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Mental/Emotional Upset	<input type="radio"/> Y <input checked="" type="radio"/> N
Tuberculosis	<input type="radio"/> Y <input checked="" type="radio"/> N	Hypertension	<input type="radio"/> Y <input checked="" type="radio"/> N	Attempted Suicide	<input type="radio"/> Y <input checked="" type="radio"/> N
Sexually Transmitted Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Epilepsy/Convulsions	<input type="radio"/> Y <input checked="" type="radio"/> N	Asthma/Emphysema	<input type="radio"/> Y <input checked="" type="radio"/> N
Ulcers	<input type="radio"/> Y <input checked="" type="radio"/> N	Hemophiliac (bleeder)	<input type="radio"/> Y <input checked="" type="radio"/> N	Cancer	<input type="radio"/> Y <input checked="" type="radio"/> N
Kidney Trouble	<input type="radio"/> Y <input checked="" type="radio"/> N	Aids/Exposed to Aids	<input type="radio"/> Y <input checked="" type="radio"/> N	Diabetes	<input type="radio"/> Y <input checked="" type="radio"/> N
DT's	<input type="radio"/> Y <input checked="" type="radio"/> N	Skin Problems	<input type="radio"/> Y <input checked="" type="radio"/> N	Use Insulin	<input type="radio"/> Y <input checked="" type="radio"/> N
Drug Addiction	<input type="radio"/> Y <input checked="" type="radio"/> N	Alcoholism	<input type="radio"/> Y <input checked="" type="radio"/> N	Mental Illness	<input type="radio"/> Y <input checked="" type="radio"/> N
Recent Head Injury	<input type="radio"/> Y <input checked="" type="radio"/> N	Coughed/Passed Blood	<input type="radio"/> Y <input checked="" type="radio"/> N	Recent Hospital Patient	<input type="radio"/> Y <input checked="" type="radio"/> N
Recent Treatment	<input type="radio"/> Y <input checked="" type="radio"/> N	Use Needles	<input type="radio"/> Y <input checked="" type="radio"/> N	False Limbs/Teeth	<input type="radio"/> Y <input checked="" type="radio"/> N
Contagious Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Pregnant/Recent Delivery	<input type="radio"/> Y <input checked="" type="radio"/> N		

Doctors Name and Address

NONE

Health Insurance

NONE

Special Diet

NONE

Prescriptions/Medications

NONE

Drug Allergies

NONE AWARE OF

Descriptions

INMATE APPEARS FINE AT TIME OF INTAKE

I have read the above carefully and have answered all questions correctly to the best of my knowledge.

Inmate's Signature _____ Date: _____ Time: _____

Officers's Signature _____ Date: _____ Time: _____

CJ012 PORTREY, CLIFF

MEDICAL STAFF RECEIVING SCREENING FORM

(NAME) Boylett FIRST NAME AL MIDDLE Everett INTAKE DATE 6/7/05 SCREENING DATE 6/8/05 FILE # 0745
 PREVIOUS INCARCERATIONS None SEX Male SOCIAL SECURITY # 416-081511 DOB 1-5-65
 REPORT INSURANCE COVERAGE? None CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION NO

GENERAL / MEDICAL OBSERVATION: (Explain all "Yes" Answers) Circle Y or N:

Is the inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral?
 yes ☐ NO ☒

Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries, needle marks, body vermin?
 yes ☐ NO ☒

Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior?
 yes ☐ NO ☒

Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol?
 yes ☐ NO ☒

Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc.
 yes ☐ NO ☒

ASK THE INMATE THESE QUESTIONS: (Explain all "Yes" answers)

Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions?
 yes ☐ NO ☒

Have you taken or are you taking any medication(s) prescribed for you by a physician?
 yes ☐ NO ☒

Are you allergic to any medications, foods, plants, etc.?
 yes ☐ NO ☒

Have you fainted or had a head injury within the last 72 hours?
 yes ☐ NO ☒

Have you ever been exposed to AIDS, hepatitis, TB, VD, or other communicable disease?
 yes ☒ NO ☐

Have you been hospitalized by a physician or psychiatrist within the last year?
 yes ☒ NO ☐

Have you ever considered or attempted suicide?
 yes ☐ NO ☒

Do you have a painful dental condition?
 yes ☐ NO ☒

Are you on a specific diet prescribed by a physician?
 yes ☐ NO ☒

Do you use drugs? How often? daily
 What kind? Marijuana, Cocaine, Lortabs Last time? 3-4 days ago
 How much? 10 tabs

Do you use alcohol? How often? daily
 What kind? beer Last time? 2 days
 How much? 6 pk

Males: LMP Date.

Are you pregnant, recently delivered or aborted; on birth control pills; having abdominal pain or discharge?
 yes ☐ NO ☒

OBTAIN VITAL SIGNS:

Respiration: 20 Pulse: 107 Temperature: 97.4 Blood Pressure: 107/78

HAVE ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE? Yes

RE ALL STATED CHRONIC CONDITIONS NOTED: Yes

ID IMPLANTED? Y OR N ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAYS. Yes

REMARKS: Denies being symptomatic

I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication upon release. I hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc.

Inmate's Signature: Al Boylett

Interviewer's Signature and Title: E. Lyons CPA

Date: 6-8-05

Date: 6-8-05



INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip, and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 6-13-05 Pod/Location: B Cell: Floor ID# _____

Inmate's Full Name: Al E Boyett

Complaint/Problem: Ear Infection

How long have you had this problem? 6-12-05

Inmate's Signature: Al Boyett Date: 6-13-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 97.3 Resp 18 Pulse 71 B/P 111/67

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

40 of feeling step up Bil Ears
Noted ear wax built up in (L) ear -
(100%) (1) Earwax removal kit
5-10 drops BID x 4 da

☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order

☐ Follow-Up Required? If checked, date to be seen again _____

☐ Chronic Condition

☒ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 6/14/05 Seen by: [Signature]

Place original form in patient's medical record.

6-17-05- Returned i 40 earache. Red swollen inside. Amoxicillin.



INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay for this facility.

Today's Date: 6-17-05 Pod/Location: B Block Cell: B-7 ID# _____

Inmate's Full Name: Al Boyett

Complaint/Problem: My ear popped and is throbbing
and I need to see the doctor
immediately

How long have you had this problem? Since Tuesday of this week
is when it started.

Inmate's Signature: Al Boyett Date: 6-17-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 96.8 Resp 20 Pulse 78 B/P 106/64

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

Refer to M.D.

Both ears impacted - wax - fear wax not in

Ibuprophen 800mg. 1 PO BID x 7 days

Leg cramps

(No charge for up visit)

☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order

☐ Follow-Up Required? If checked, date to be seen again _____

☐ Chronic Condition

☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 6/18/05 Seen by: C. Lymocan

Place original form in patient's medical record.

Southern Health Partners, Inc.

ADMISSION DATA / HISTORY AND PHYSICAL FORM

Exam Date: 6/19/05 S.S.#: 416-08-1511 ID#: _____
 Inmate Name: Boyet AL EVERITT Date Booked: _____
 Alias: _____ (Last) (First) (Middle) County: _____
 Address: _____ (Street) (City) (State) (Zip)
 Telephone: _____ Birthdate: 1-15-65 Religion: _____
 Education Completed: _____ Special Education: _____
 Marital Status: S M W D Separated Read/Write English: YES NO Other: _____
 Previous Incarcerations: (Facility/Date) _____

MEDICAL HISTORY

Notify in Emergency: _____
 Address: _____ (Name) (Street) (City) (State) (Zip) (Relationship) Phone: _____
 Health Insurance: _____ (Type of Insurance) (State) (Policy Number)
 Family Physician: _____ (Name) (Street Address) (City) (State) (Zip) (Phone Number)
 Past Hospitalizations (include surgeries): Vehicle accident 1996
 Head Injury with Loss of Consciousness: Yes Last Tetanus: _____ (City) (State) (Zip) Immunization: _____
 Allergies: Vehicle accident
 Current Medication(s): _____

MENTAL HEALTH EVALUATION

Hospitalization for Mental Health Reasons: YES NO If Yes, Why: Mental dest done
 Where: Cery Mental Health MI AL When: 1996
 (Location) (Street Address) (City) (State) (Zip) (Date)
 Psychotropic Meds (Specify type and last dose): Nerve meds
 Prior Counseling/Out-Patient Treatment for: Yes
 Where: Andalusia Mental Health due to vehicle accident
 (Location) (Street Address) (City) (State) (Zip) When: _____ (Date)
 Have you ever attempted suicide: NO How: _____ When: _____ (Date)
 Have you recently considered committing suicide? NO When: _____ (Date)
 Do people consider you a violent person? NO
 Have you ever been arrested for a violent crime/sexual offense? (Specify) domestic violence July 05
 Street drugs: meth cocaine marjuana (How Often) (How Long) Smoker: Yes Etch: Yes (Type) (Date)
 Inmate's Signature: AL Boyett
 Interviewer's Signature: C. Upmorn Date: 6/19/05
 Witness: (if physical is refused): _____ Date: 6/19/05
 Date: _____

MEDICAL HISTORY & PHYSICAL ASSESSMENT

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Vision <i>Reading</i>	✓		Hypertension		✓	Gonorrhea		✓
Hearing	✓		Anemia		✓	Syphilis		✓
Balance/Dizziness	✓		Blood		✓	Muscle Problem	✓	<i>leg & toe cramps</i>
Blackouts		✓	Stomach Pain <i>leg</i>		✓	Joint Problem		✓
DT's		✓	Heartburn		✓	Arthritis		✓
Headaches		✓	Ulcer		✓	Other		
Seizures		✓	Nausea/Vomiting		✓	Other		
Nervous Disorder		✓	Gall Bladder		✓	Regular Menstrual Period		
Throat		✓	Liver		✓	Irregular Menstrual Period		
Teeth <i>caries</i>	✓		Hepatitis		✓	# of days Menstrual Period		
Asthma		✓	Diabetes		✓	LMP		
Hay Fever		✓	Kidney Disease		✓	Gravida/Para		
Pneumonia		✓	Bladder Infection		✓	Last Pap		
Tuberculosis		✓	Trouble Voiding		✓	Contraception		
Heart		✓	Pediculi (lice)		✓	Other		

EXAM:

Age 41 Sex M Race W Ht. 5'7 Wt. 150

Pulse 81 BP 113/74 Temp. 95.7 Resp. 20

Area/Type	N	A/Comment	Area/Type	N	A/Comment
Skin: Color Condition Turgor Recent Inj.	✓		Chest (Breasts): Configuration Auscultation Respirations Cough/Sputum		<i>all lungs</i>
Head: Glasses Pupils Sclera Conjunctiva Vision		<i>Reading difficulty</i>	Heart: Auscultation Radial pulses Apical pulse Rhythm	✓	
Ears: Appearance Canals Hearing		<i>impacted - wax damaged pain behind</i>	Extremities: Pulses Edema Joints		<i>leg & toe cramps</i>
Mouth: Teeth/Gums Dentures Plates Throat Tongue Tonsils	✓		Abdomen: Shape Palpation Hernia Bowel Sounds	✓	<i>RT quad. abd. pain mid-abd. pain epigastria</i>
Nose	✓		Spine	✓	
Neck: Veins Mobility Thyroid Carotids Lymph nodes	✓		Genital/Urinary System	✓	

LABORATORY TESTS

	Date & Initial	Results
Was PPD planted and read timely?		
VDRL / RPR		
Other Lab Tests needed:		
Pregnancy Test?		

MENTAL HEALTH OBSERVATION

	N	A/Comment
Orientation (person, place, time)	✓	
General appearance (motor behavior, mannerisms)	✓	
Affect (mood)	✓	
Content of thought, history of suicide, present thoughts of suicide	✓	

Physical Examiner's Signature: *[Signature]*

Physician's Signature: *[Signature]*

Date: *6/19/05*

6-17-05 Al. Bayett L-5-65 416-08-1511

6/17/05 Ear Canal red swollen c/o pain in ear. Started on Amoxicillin
500 mg tid po BID x 7 days. Cont. c ear wax removal - S. Dr. McWhorter Pl

6/22/05 Seen by Dr. McWhorter. C/o also pain
problems & impacted ear wax. New
order Manta 150mg BID. Place
g Hs to both ears qd.



INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for the inmate to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay for this facility.

Today's Date: 6-24-05 Pod/Location: B Block Cell: _____ ID# _____

Inmate's Full Name: Al E Boyett

Complaint/Problem: Eat are getting worse instead of better follow up

How long have you had this problem? 2 weeks

Inmate's Signature: Al Boyett Date: 6-24-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp _____ Resp _____ Pulse _____ B/P _____

Instructions/Assessment: Document your findings, inmate's responses/actions _____

Referred to M.D

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again _____
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: _____ Seen by: [Signature]

Place original form in patient's medical record.

COVINGTON COUNTY JAIL
INMATE REQUEST/GRIEVANCE FORM

NAME: Al Rayett BLOCK: B DATE: 6-28-05

TELEPHONE CALL CUSTODY CHANGE () PERSONAL PROBLEM

SPECIAL VISIT () TIME SHEET ☒ OTHER () GRIEVANCE

BRIEFLY OUTLINE YOUR REQUEST/ GRIEVANCE. THEN PRESENT TO C/O

REQUEST PLEASE CHECK TO WHOM IT IS DIRECTED TO:
SHERIFF CHIEF JAILER () JAILER () RECORDS OFFICE () CHAPLAIN

GRIEVANCE STATE PARTIES INVOLVED AND NAMES OF WITNESSES IF APPLICABLE
Doctor It seem's that every thing you've
tried hasn't worked for my pain and I wish you
would let me see a doctor that could take
care of it this has been going on over 2 weeks
and I need some kind of relief from the pain that
it is causing

10 see today
MD
6/29/05
See [signature]

DO NOT WRITE BELOW THIS LINE -- FOR REPLY ONLY:

APPROVED () DENIED () PAY PHONE () COLLECT () OTHER

ALABAMA / MISSISSIPPI
1-800-845-8183**SOUTHERN RADIOLOGY
SERVICES, LLC**Please Indicate Patient Status
☒ Medicare Part A Patient (Skilled)
☒ 3rd Party (Non-Skilled)
☐ VA Patient
☐ Employee

PLEASE PRINT

PATIENT: <u>11</u>		RESPONSIBLE PARTY INFORMATION (MUST BE COMPLETED FOR ALL PATIENTS)	
DOB: <u>1-15-65</u> SEX: <u>M</u> F ROOM # <u>C</u>	NAME: <u>Southern Health Partners</u>	PHONE #:	
FACILITY: <u>Cov. County Jail</u>	ADDRESS: <u>3712 Fingert Rd #304</u>	CITY: <u>HATTANOOGA</u>	STATE: <u>TN</u> ZIP: <u>37412</u>
PHONE: <u>334-422-2640</u> FAX: <u>334-428-2055</u>			
SS#: <u>416-08-1511</u>			
MEDICARE #:	CODE	PATIENT SIGNATURE: _____ Patient's or Authorized Person's Signature: I authorized the release of any medical or other information necessary to process this claim. I request payment of government/insurance benefits be made to the provider performing services.	
MEDICAID #:	CODE		
INSURANCE	CODE		
INSURANCE #:	PRE CERTIFICATION #		

Patient Unable to Sign

EXAMS REQUESTED: Please Mark Each Clearly
X-RAY EXAMS

74000	Abdomen, 1 View	73520	Hip, Min 2 Views w/Pelvis L R	73590	Tibia/Fibula, 2 Views L R
73600	Ankle, 2 Views (AP 7 LAT) L R	73510	Hip, Comp Min 2 Views L R	73100	Wrist, 2 Views L R
73510	Ankle, Comp Min 3 Views L R	73080	Humerus, Min 2 Views L R	73110	Wrist, Min 3 Views L R
73650	Calcaneus (Heel), 2 Views L R	73560	Knee, 2 Views L R		OTHER
71010	Chest, 1 View (AP)	73562	Knee, 3 Views (inc OBLQ) L R		OTHER EXAMS L R
		70160	Nasal Bones, Comp Min 3 Views		
71111	Chest With Ribs, 4 Views	72170	Pelvis, 1 Views		
73000	Clavicle, Complete L R	71100	Ribs, 2 Views L R	93000	EKG Pacemaker Y N
73070	Elbow, 2 Views L R	72220	Sacrum/Coccyx, Min 2 Views	95819	EEG
73080	Elbow, Comp 3 Views L R	73030	Shoulder, Min 2 Views L R		
73550	Femur, 2 Views L R	70210	Sinuses, Less Than 3 Views		
73020	Foot, 2 Views L R				
73630	Foot, Comp Min 3 Views L R	70250	Skull, Less Than 4 Views		
73090	Forearm, 2 Views L R	72040	Spine, Cervical 2 Views		
73120	Hand, 2 Views L R	72100	Spine, Lumbosacral 2 Views		
73130	Hand, Min 3 Views L R	72070	Spine, Thoracic 2 Views		

DIAGNOSIS/SYMPOM(S): Please Mark ALL that apply

787.3	Abdomen Distention (Flatulence)	498	COPD, Chronic Obstructive Pulm Dis	560.9	Obstruction, Intestinal
787.5	Abnormal Bowel Sounds	786.2	Coughing		Pain in <u>Right</u>
413.0	Angina		Dislocation of	485	Pneumonia, Confirmed
	Arthritis of	780.4	Dizziness	514	Pneumonia, Probable
429.2	ASCVD, Atherosclerotic cardiovas Dis	787.2	Dysphagia (Difficulty Swallowing)	795.5	Positive Mantoux, PPD
427.31	Atrial Fibrillation	782.3	Edema (Swelling)	518.4	Pulmonary Edema, NOS
507.0	Aspiration	492.0	Emphysema	515	Pulmonary Fibrosis
427.89	Bradycardia	780.6	Febrie (Feverish)	786.7	Rales in Chest
	Bruise of		Possible Fracture of	786.09	Shortness of Breath
466.0	Bronchitis, NOS	560.39	Impaction	780.2	Syncope & Collapse
	Carcinoma of	518.3	Infiltrate, Lung	785.0	Tachycardia
429.3	Cardiomegaly	410.92	Myocardial Infarction	011.90	Tuberculosis
786.50	Chest Pain, Unspecified	787.01	Nausea and Vomiting	519.8	URI (Chronic)
514	Congestion, Chest				OTHER
428.0	Congestive Heart Failure				

PHYSICIAN'S SIGNATURE: _____	NURSE'S SIGNATURE: <u>E. Calum</u>	X-RAY #	TECH <u>83</u>
ORDERING PHYSICIAN: <u>Michael</u>	CODE	DATE: <u>8-16-05</u>	# VIEWS <u>3</u>
PHONE #:		ARRIVE TIME: <u>11:05 AM</u>	Q0092 # <u>1</u>
FAX:		DEPART TIME: <u>11:25</u>	# PTS SEEN <u>1</u>
RADIOLOGIST: _____			
PRELIMINARY REPORT: _____			
AM			
TIME			
PM			

08/18/2005 13:00

Sherri Matuff

Page 2/2

**SOUTHERN RADIOLOGY SERVICES, LLC
X-RAY REPORT**

DATE	LAST NAME	FIRST NAME	MI
8/16/2005	BOYETTE	AL	
D.O.B.	SEX	FACILITY	
1/15/1965	M	SHP-COVINGTON COUNTY JAIL	
ORDERING PHYSICIAN		X-RAY NO.	
MCWATER			

IMAGES OF THE LEFT HAND, 8/16/05**HISTORY:** Edema.

Patient had trauma the week prior. Patient sustained a fracture to the neck of the fifth metacarpal without gross displacement. There is no dislocation noted either. No additional acute fracture is identified. There is a prominent spur at the distal end of the fifth digit proximal phalanx that could be related to the old trauma. No acute foreign bodies suggested.

IMPRESSION: Nondisplaced fracture of the distal fifth metacarpal.

Vincent Martin, M.D./kmc

tt: 8/16/2005 12:48:12 PM

td: 8/16/2005 12:37:50 PM

PROGRESS NOTES

414-08-1511

Last Name Bayott, K First Name K Attending Physician Dr. Muehler Room No Hosp. No.

Date

Notes Should Be Signed by Physician

6/29/05 S - inmate is C/O ear congestion
& leg cramps. BP 8/55 P 97 R 18
Temp 99.1

Q ears - fluid behind TM's

A. chronic sinusitis
leg cramps

R Orobafon 750mg \div fab BID
x 10 d

② Penicillamine 3R \div caps BID x 300.

Regall x 2

~~Plasma~~
note

6/29/05

[Signature]

8/17/05 S - C/O fracture of Oribital
N/C

T-97!

P-100

R-2-4

Bp-135

100

Q inmate injured the elbow
No fx, but severe swelling
sent back to hospital for test

A - C/O x-ray Oribital & ② A

[Signature]
8/24/05 N/C

Dr. _____

500mg BID
x 100 d

Southern Health Partners, Inc.

ADMISSION DATA / HISTORY AND PHYSICAL FORM

Exam Date: 8/25/05 S.S.#: 416-08-1511 ID#: _____
 Inmate Name: Bayette M Date Booked: 8-15-05
 Alias: A (Last) (First) (Middle)
 Address: 14960 Hogfast Rd Andalusia AL County: COV
 Telephone: 222-5452 Birthdate: 1-15-65 (City) (State) (Zip)
 Education Completed: 8th Special Education: _____
 Marital Status: M W D Separated Read/Write English: YES NO Other: _____
 Previous Incarcerations: (Facility/Date) 2005-

MEDICAL HISTORY

Notify in Emergency: Voncie Mc Cart (Name)
 Address: 14692 Hogfast Rd Andalusia AL 36420 (Street) (City) (State) (Zip)
 Health Insurance: GO (Type of Insurance) Phone: 222-5452 (Relationship)
 Family Physician: Dr. Vigan, Ugo Andalusia AL 36420 (Name) (Street Address) (City) (State) (Zip) (Phone Number)
 Past Hospitalizations (include surgeries): 0

Head Injury with Loss of Consciousness: A (Location) (Street Address) (City) (State) (Zip)
 Allergies: B NKA Last Tetanus: 2003 Immunization: _____
 Current Medication(s): None

MENTAL HEALTH EVALUATION

Hospitalization for Mental Health Reasons: YES NO If Yes, Why: Mental Breakdown
 Where: Searcy Dauphin AL When: March 1984
 (Location) (Street Address) (City) (State) (Zip) (Date)
 Psychotropic Meds (Specify type and last dose): 0
 Prior Counseling/Out-Patient Treatment for: Mental Health 1987
 Where: Andalusia AL 36420 When: _____
 (Location) (Street Address) (City) (State) (Zip) (Date)
 Have you ever attempted suicide: NO How: _____ When: _____
 Have you recently considered committing suicide? NO (Date)
 Do people consider you a violent person? Yes
 Have you ever been arrested for a violent crime/sexual offense? (Specify) NO
 Street drugs: Marijuana - Wkly 1yr Smoker: Yes Etoh: Yes
 (Type-Quantity) (How Often) (How Long) (Type) (Date)
 Inmate's Signature: _____ Date: _____
 Interviewer's Signature: al Bayette Jr Date: 8-25-05
 Witness: (if physical is refused): J. Colvin Jr Date: 8-25-05

MEDICAL HISTORY & PHYSICAL ASSESSMENT

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Vision	✓		Hypertension		✓	Gonorrhea		✓
Hearing		✓	Anemia		✓	Syphilis		✓
Balance/Dizziness	✓		Blood	✓		Muscle Problem	✓	
Blackouts		✓	Stomach Pain	✓		Joint Problem	✓	
DT's		✓	Heartburn	✓		Arthritis	✓	
Headaches	✓		Ulcer		✓	Other		
Seizures		✓	Nausea/Vomiting		✓	Other		
Nervous Disorder	✓		Gall Bladder		✓	Regular Menstrual Period		
Throat	✓		Liver	✓		Irregular Menstrual Period		
Teeth	✓		Hepatitis	✓		# of days Menstrual Period		
Asthma		✓	Diabetes		✓	LMP		
Hay Fever		✓	Kidney Disease		✓	Gravida/Para		
Pneumonia		✓	Bladder Infection		✓	Last Pap		
Tuberculosis		✓	Trouble Voiding	✓		Contraception		
Heart	✓		Pediculi (lice)		✓	Other		

EXAM:Age 40 Sex M Race W Ht. 5'7" Wt. 145

Area/Type	N	Pulse	BP	Temp.	Resp.	Area/Type	N	A/Comment
Skin: Color Condition Turgor Recent Inj.						Chest (Breasts): Configuration Auscultation Respirations Cough/Sputum	✓	
Head: Glasses Pupils Sclera Conjunctiva Vision	✓					Heart: Auscultation Radial pulses Apical pulse Rhythm	✓	
Ears: Appearance Canals Hearing	✓					Extremities: Pulses Edema Joints	✓	
Mouth: Teeth/Gums Dentures Plates Throat Tongue Tonsils						Abdomen: Shape	✓	
Nose	✓					Palpation Hernia Bowel Sounds	✓	
Neck: Veins Mobility Thyroid Carotids Lymph nodes	✓					Spine	✓	
						Genital/Urinary System	✓	

LABORATORY TESTS

	Date & Initial	Results
Was PPD planted and read timely?	6/24/05	neg
VDRL / RPR	NA	
Other Lab Tests needed:	NA	
Pregnancy Test?		

MENTAL HEALTH OBSERVATION

	N	A/Comment
Orientation (person, place, time)	✓	
General appearance (motor behavior, mannerisms)	✓	
Affect (mood)		
Content of thought, history of suicide, present thoughts of suicide		None

Physical Examiner's Signature: [Signature]Physician's Signature: [Signature]Date: 8-25-05



INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correct officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 9-3-05 Pod/Location: C Black Cell: _____ ID# _____

Inmate's Full Name: Al Bayett JR

Complaint/Problem: Sore's on butt pain almost impossible to stand and there is drainage at times

How long have you had this problem? More than a week

Inmate's Signature: Al Bayett Date: 9-3-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 98.8 Resp 16 Pulse 64 B/P 108/70

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

See Above - 1/2 dose in tank area 11 (pus) + drainage, pus + drainage noted, order's Docusylline 10mg PO Bid x 10 days, 800 PO Bid x 10 days, Nitrofurantoin 3x bid.

Dr. Williams, MD

- ☐ Received Orders - thru Treatment Protocols; via telephone order; via verbal order
- ☒ Follow-Up Required? If checked, date to be seen again 10 needed
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 9-3-05 Seen by: Dr. Williams, MD

1. *Phragmites australis* (Cav.) Trin. ex Steud.

Abstracts

2. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

1. *Journal of the American Medical Association*, 1997; 278: 1025-1030.

Date:

Notes Should Be Signed by Physician

9-7

T-90

P. 74

R-14

9/13/9 - 102
770


5 - Mrs. Rep. C.

6 - Has lab results revealing
+ HEP L.

A- Hfo Nep C

Q. May see his own MD for
at his own expense

Wally La
9/7/51





INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correction officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 10-7-05 Pod/Location: C Block Cell: _____ ID# _____

Inmate's Full Name: Al Boyett

Complaint/Problem: I have a boil on bite own inner thigh

How long have you had this problem? A week or more

Inmate's Signature: Al Boyett Date: 10-7-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp _____ Resp 18 Pulse 84 B/P 104/65

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

Sores noted on groin area (L & R)
(L) side very large & redness & redness
ap same groin - not state (1) Bothers DS + PC
he has on on genital also. BID x 10
Heard Stomach 3x weekly. (2) Dexamethasone 100 mg
+ PC BID x 10
(3) Penicillin 100 mg
+ PC BID x 10

- ☐ Received Orders - thru Treatment Protocols; via telephone order; via verbal order
- ☒ Follow-Up Required? If checked, date to be seen again: MD @ next time
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 10/7/05 Seen by: [Signature]

~~Doctor~~ **SICK CALL
REFUSAL FORM**

I, Al Boyett (inmate name) understand that my name is on the sick call list to be seen by Southern Health Partners medical staff at Covington County Jail, and that I am declining to be seen at this time. I further understand that it will be documented as such in my medical file, and that my name will NOT be added back to sick call, unless I submit another sick call request.

Al Boyett
Inmate Signature

10/12/05
Date/Time

[Signature]
Witness Signature

10/12/05
Date/Time

Nurse Signature

Date/Time Noted

COVINGTON COUNTY JAIL
INTE REQUEST/GRIEVANCE FORM

NAME Al Boyett BLOCK C Block DATE 10-21-05

TELEPHONE CALL

CUSTODY CHANGE

PERSONAL PROBLEM

SPECIAL

TIME SHEET

(☒) OTHER

() GRIEVANCE

BRIEFLY OUTLINE YOUR REQUEST/ GRIEVANCE. THEN PRESENT TO C/O

REQUEST PLEASE CHECK TO WHOM IT IS DIRECTED TO

SHERIFF

CHIEF JAILER

()

JAILER

()

RECORDS OFFICE

CHAPMAN

GRIEVANCE STATE PARTIES INVOLVED AND NAMES OF WITNESSES IF APPLICABLE.

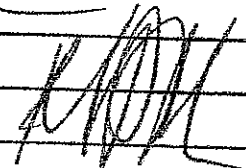
Dr McWhorter sir

Would you please set An Appointment for an RNA
Test for HCV so I may have proper medical Attention
A waiting your speedy reply.

10/24/05

inmate requesting Hep. C profile to determine
his stage of Dz.

gruter



DO NOT WRITE BELOW THIS LINE - FOR REPLY ONLY:

APPROVED

()

DENIED

()

PAY PHONE

()

COLLECT

()

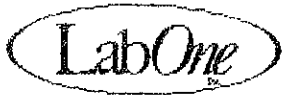
OTHER

5-NOV-2005

22:20

LabOne, Inc.

Page 1

10101 Renner Boulevard
Lenexa, KS 66219

For Customer Service, call 1-800-646-7788

Site #: 0100177853

Report: 1/1

Distribute to: .

PATIENT: BOYETT, AL
CLIENT PATIENT ID: ?
REQ NUMBER: 89482338-16
ID DR ROOM NO: UNKNOWN
PAGE DOB/AGE: Jan 15 1965/40 YEARS
1 SEX: U FASTING: YES HRS:
DATE/TIME COLL: Nov 01 2005 03:50 PM
DATE RECEIVED: Nov 03 2005 04:50 AM
DATE REPORTED: Nov 04 2005
DATE RE-SENT: Nov 05 2005
REPORT STATUS: FINAL REPORT

ACCOUNT: EBV3
REF DR: UNKNOWN
SHP COVINGTON COUNTY JAIL
290 HILLCREST DR
ANDULUSIA, AL 36420

RESULT NAME IN RANGE OUT OF RANGE REFERENCE UNITS
Gender not specified, reference ranges default to male where applicable.

HEPATITIS TEST

HEPATITIS C Ab

POSITIVE

NEGATIVE

HIV TYPES 1/2 AB EIA

NEGATIVE

NEGATIVE

If this test is ordered as a follow-up test on a patient with a reactive rapid HIV antibody result, CDC recommends supplemental testing with Western blot, even if the EIA result is negative.

END OF REPORT FOR BOYETT, AL



INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the nurse officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange to be seen by the appropriate medical staff member. You will be charged in accordance with the medical policy of this facility.

Today's Date: 11-1-05 Pod/Location: C Block Cell: _____ ID# _____

Inmate's Full Name: Al E Boyett Jr

Complaint/Problem: Risen's are coming back on me I also have a brown spot on leg that is red spreading And has reached other leg.

How long have you had this problem? Over A Week

Inmate's Signature: Al Boyett Date: 11-01-05

TO BE COMPLETED BY MEDICAL STAFF:

Take Patient's Vital Signs: Temp _____ Resp _____ Pulse _____ B/P _____

Instructions/Assessment: Document your findings, Inmate's response/condition. I-See Above

O- inmate has areas on his leg and buttocks

A- inmate has Chronic hx as well as hep C

P- Doxycycline 100mg BID X 10D, BACTAM DS + po BID X 10D, IBU 800mg BID X 10D, Tylenol BID prn

- ☒ Received Orders – thru Treatment Protocols: via telephone order, via mail, or other
- ☐ Follow-Up Required? If checked, date to be seen again _____
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Seen by Medical: 11/1/05 Seen by: JM

Inmate Name: Bovette AL

SS#:

DOB:

Allergies:

Facility:

Covington

County

Jail

Date: 11/17/05

Date:

Miconazole Cream to

Opinitas Area BLD

5.0. Gr. me photo, match

M.D. Sig:

M.D. Sig:

Date:

Date:

M.D. Sig:

M.D. Sig:

Date:

Date:

M.D. Sig:

M.D. Sig:

Date:

Date:

M.D. Sig:

M.D. Sig:

(B)

Time From <u>6-1-05</u> <u>On McWhorter</u>		THROUGH <u> </u>	
Telephone No. <u> </u>		Medical Record No. <u> </u>	
Alt. Telephone <u> </u>		Rehabilitative Potential <u> </u>	
Card Number <u> </u>		Medicare Number <u>416-08-1511</u>	
Approved By Doctor: <u> </u>		By: <u> </u>	
Title: <u> </u>		Date: <u> </u>	

ATTENDING DOG		THROUGH	
2-1-05		2-31-05	
Physician		Telephone No.	
NEW HAVEN		Alt. Telephone	
Notes		Medical Record No.	
NKA			
Diagnosis		Rehabilitative Potential	
Medicaid Number	Medicare Number	Approved By Doctor:	
	416-08-15-11	By:	
		Title:	Date:

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOURS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Procton D ₅₀ TPO BID x 10	AM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
10/7/05 - 10/17/05	PM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Doxycycline 100 mg PO BID x 10	AM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
10/7/05 - 10/17/05	PM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Procton D ₅₀ TPO BID x 10	AM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
10/7/05 - 10/17/05	PM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Nikolova Spikes 3 x wky		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

STARTING FOR	10/7/05	THROUGH	10/31/05
Physician	Dr. Muehntor	Telephone No.	
Address	NILQA	Alt. Telephone	
Notes		Rehabilitative Potential	
Medicaid Number	41608-1511	Approved By Doctor:	
		By:	
		Title:	
		Date:	